Endobronchial Tuberculosis with Anthracofibrosis

Laura M. Paulin¹, Natalie E. West¹, Jason A. Akulian², and Brian T. Garibaldi¹

¹Division of Pulmonary/Critical Care, Johns Hopkins University School of Medicine, Baltimore, Maryland; and ²Division of Pulmonary Diseases and Critical Care Medicine, University of North Carolina School of Medicine, Chapel Hill, North Carolina

Figure 1.

A 76-year-old woman presented with several months of cough, fatigue, and audible inspiratory wheeze. Chest computed tomography revealed bilateral lower lobe ground glass infiltrates, multiple sub-centimeter pulmonary nodules, and narrowing of the proximal right main stem bronchus (Figure 1A, arrow). Bronchoscopy revealed flat, friable, darkly pigmented submucosal lesions (Figure 1B) and stenosis of the right main stem bronchus (Figure 1C). Smear microscopy of bronchoalveolar lavage fluid from the right middle lobe was positive for acid-fast bacilli, and culture grew *Mycobacterium tuberculosis* (MTB). The patient was treated with anti-MTB medications, and her symptoms improved.

First described in 1951 on gross pathology by Cohen (1), anthracofibrosis was defined in 1998 by Chung and colleagues as bronchial narrowing with dark anthracotic pigmentation on bronchoscopy (2). In prior studies, 20 to 60% of patients with anthracofibrosis were found to have MTB (3); it is believed that inflammation of lymph nodes leads to pigment deposition and stenosis in the adjacent airway (2). Anthracofibrosis has also been associated with exposure to biomass fuels, but in the majority of cases the causative factor remains unknown (3). In the correct clinical setting, lesions such as these seen during bronchoscopy should alert the physician to the possibility of an active MTB infection. ■

Author disclosures are available with the text of this article at www.atsjournals.org.

References

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